Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004392	A. BUILDING _____ B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGBY HOUSE	167 CR W 240 S LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey Dates: March 12, 13, 2012 Facility Number: 004392 Provider Number: 004392 AIM Number: N/A Survey Team: Linda Campbell, RN Census Bed Type: Residential: 36 Total: 36 Census Payor Type: Other: 36 Total: 36 Sample: 9 Digby House was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality review 3/14/12 by Suzanne Williams, RN	R 000		